**California State Board of Pharmacy**
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
Website - www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

# CHANGE OF PERMIT

### WHOLESALER, HYPODERMIC NEEDLE AND SYRINGE PERMITS

A request for a change of permit must be filed within 30 days when the following occurs:

- Change of corporate officers
- Change of tradestyle name
- Change of street name or number by the post office (not considered a change of location).
- Change of responsible managing employee (for hypodermic needle and syringe permits) or branch manager (for major out-of-state manufacturers with distribution outlets licensed as wholesalers in California).

**To be considered complete,** all of the required forms must be submitted. If the pharmacy is owned by a corporation, at least one corporate officer must sign. If it is owned by a partnership, each partner must sign; or if a sole ownership, owner must sign. Please allow four to six weeks for processing the application.

## Change of corporate officer:

[ ] 1. Processing fee of $60 for the wholesaler, or hypodermic needle and syringe permit.

[ ] 2. Completed Change of Permit form (17A-52). At least one corporate officer must sign the form.

[ ] 3. Copy of Request for Live Scan Service Form verifying that your fingerprints have been scanned and all applicable fees have been paid for each new officer. (Please refer to fingerprint instructions on page 3.)

[ ] 4. Completed Individual Certification Affidavit (17A-37) form for each new corporate officer.

[ ] 5. Attach one of the following:

   a. Statement of Domestic Stock endorsed by the Secretary of State reflecting the corporate officer change, OR
   b. A copy of the board minutes reflecting the change of corporate officers.

[ ] 6. If Indian owned, a copy of the constitution and by-laws establishing the tribal council that will be the governing entity of the pharmacy.

**Exceptions**: Fingerprints and Individual Certification Affidavit are not required if the change of corporate officers is for a major out-of-state manufacturer who has its California distribution outlet licensed as a wholesaler; and if the change is not the vice-president of operations (or an individual at the corporate level identified as directly responsible for the distribution of products). If the change is the vice-president of operations, fingerprints and certification of personnel are required.

**Change of tradestyle name or corporation name:**

[ ] 1. Processing fee of $30 for the facility permit plus $30 for each exemption certificate.

[ ] 2. Completed Change of Permit form (17A-52). If the facility is owned by a corporation, at least one corporate officer must sign. If it is owned by a partnership, each partner must sign, or if sole ownership, the owner must sign.

[ ] 3. Attach a fictitious name statement from the county; a copy of the articles of incorporation listing the new name; OR a copy of the board minutes ratifying the name change.

**Change of street name or number**:

If this change is made by the post office. A change of location requires the filing of an application for a new permit.

[ ] 1. Processing fee of $60 for the facility permit plus $30 for each exemption certificate.

[ ] 2. Completed Change of Permit form 17A-52). If the facility is owned by a corporation, at least one corporate officer must sign. If it is owned by a partnership, each partner must sign, or if sole ownership, the owner must sign.

**Change of responsible managing employee**

Hypodermic Needle and Syringe Permit or change of distribution branch manager (for major out-of-state manufacturer with distribution outlets licensed in California as wholesale firms).

[ ] 1. Processing fee of $60.

[ ] 2. Completed Change of Permit form (17A-52). If the facility is owned by a corporation, at least one corporate officer must sign. If it is owned by a partnership, each partner must sign, or if sole ownership, the owner must sign.

[ ] 3. Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid for each new officer. (Please refer to fingerprint instructions on page 3.)

[ ] 4. Completed Individual Certification Affidavit (17A-37) form for the new responsible managing employee or distribution branch manager.

**Lost, stolen or mutilated permit**

The fee for issuing a duplicate license is $30. Please contact the board for the proper forms.

## Fingerprint Requirements

### California Residents

The board will only accept Live Scan Service Forms from California residents.

***Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning.*** Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at http://caag.state.ca.us/app/contact.pdf or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

### Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of $42 ($32 California Department of Justice (DOJ) fee and $10 DOJ expedite fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

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# CHANGE OF PERMIT REQUEST

Wholesaler, Medical Device Retailer, Hypodermic Needle and Syringe Permits

(Print or type)

**Type of Change:**

- ☐ Corporate officers
- ☐ Tradestyle name or corporation name change
- ☐ Change of street name or number made by postal service
- ☐ Change of responsible managing employee
- ☐ Change of branch manager

**Current Permit Reads**:

| Name of Corporation | | | Telephone No ( ) |
|---|---|---|---|
| Address | City | State | Zip Code |
| Name of Company | | | Permit Number |

**New Permit should read**:

| Name of Corporation | | | Telephone No ( ) |
|---|---|---|---|
| Address | City | State | Zip Code |
| Name of Company | | | Permit Number |

**List owners, partners, top 5 corporate officers, branch manager or responsible managing employee and indicate if this is a change, an addition or a deletion. List all individuals to be shown on permit, whether changed or not. Use additional sheets if needed.**

| Name | | | Residence Address | | | |
|---|---|---|---|---|---|---|
| Add / Change title | Delete / No change | Title | City | State | Zip Code | Certs F/P |
| Name | | | Residence Address | | | |
| Add / Change title | Delete / No change | Title | City | State | Zip Code | Certs F/P |
| Name | | | Residence Address | | | |
| Add / Change title | Delete / No change | Title | City | State | Zip Code | Certs F/P |
| Name | | | Residence Address | | | |
| Add / Change title | Delete / No change | Title | City | State | Zip Code | Certs F/P |
| Name | | | Residence Address | | | |
| Add / Change title | Delete / No change | Title | City | State | Zip Code | Certs F/P |

**For Office Use Only**

| | | |
|---|---|---|
| Articles of Incorporation<br>Fictitious name statement<br>Minutes<br>Statement of Domestic Stock | Approved _____<br>Denied _____<br>Date _____ | Cashier # _____<br>Date _____<br>Amount _____ |

| List all persons who hold exemption certificates: | |
|---|---|
| Name | Exemption No. |
| Name | Exemption No. |
| Name | Exemption No. |
| Name | Exemption No. |

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of license, and a violation of the Penal Code of the State of California.

I hereby certify that there have been no changes in officer(s), manager, or owner(s) that have not been reported to the Board of Pharmacy and that each such officer, manager or owner is the real party in interest with respect to his/her position and is not acting directly or indirectly as an agent, employee or representative of any other person not reported to the board.

Under penalty of perjury, under the laws of the state of California, each person whose signature appears below, certifies and says: (1) He/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) that no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate.

**Signature(s) of Applicant**:

| _____ | _____ | _____ |
|---|---|---|
| Signature of Corporate officer, partner or owner | Name (please print) | Date |
| _____ | _____ | _____ |
| Signature of Corporate officer, partner or owner | Name (please print) | Date |

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USCA 405(c)(2)(C) authorize collection of federal and employer identification number (FEIN for partnerships) or your social security number. Corporations are exempt. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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# INDIVIDUAL CERTIFICATION AFFIDAVIT

All blanks must be completed; **if not applicable enter N/A**. Failure to furnish a complete explanation or any omissions will delay the processing of your application.

Please print or type

| Full name: Last First Middle | Residence telephone: ( ) |
|---|---|
| Previous name(s) – include maiden name, also known as (AKA's), "aliases": | *Social Security number: |
| Residence address: Number and Street City State Zip | |
| Date of birth: (Month, Day, Year) | Place of birth: (City, State, Country) |

| Name and address of current employer: | | |
|---|---|---|
| Work telephone: | Present occupation: | Professional or vocational licenses held: (Specify type and number) |

| Spouse's name: Last First Middle | |
|---|---|
| Spouse's Date of Birth: | Spouse's Social Security Number: |
| Will your spouse work in any capacity under the permit? ☐ Yes ☐ No | |

| Name of applicant premises: | Applicant telephone number: |
|---|---|
| Address of applicant premises: Number and Street City State Zip | |

My position with the applicant is: (Check all that apply)

| | | | |
|---|---|---|---|
| Sole owner<br>Partner | Officer<br>Stockholder _____% | Director<br>Financier/lender | Manager<br>Other - Specify: _____ |

1. Do you have, or have you had in the last 5 years, any direct or indirect beneficial interest in any other premises licensed by any board of pharmacy? Yes ☐ No ☐

   If yes, list current direct or indirect beneficial interests (use an additional sheet if necessary). Include sites licensed in states other than California.

| Name | Address | Permit Number | Dates: From/To |
|---|---|---|---|
| Name | Address | Permit Number | Dates: From/To |
| Name | Address | Permit Number | Dates: From/To |

2. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer, veterinary retailer or any other entity licensed in this state or any other state?

   Yes ☐ No ☐

   If the answer is "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include cancelled permits. (Use additional sheets if necessary.)

| Name of Company | Type of permit | Permit number | Position held | State | Expiration date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

3. Have you ever had a permit or any professional or vocational license or registration denied, suspended, revoked, voluntarily surrendered, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state or by a federal regulatory agency?

   Yes ☐ No ☐

   If the answer is "yes," please provide company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

| Name of person or company | Type of permit | Type of action | Year of action | State |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

4. Have you ever been in violation of any provisions of pharmacy law? Yes ☐ No ☐

   If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

| Type of violation | License type | Type of action | Year of action | State |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

5. Are you currently or have you previously been associated in business with any person, partnership, corporation or other entity, or shared a financial or community property interest with any person whose permit or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state or by a federal regulatory agency?

Yes ☐ No ☐

If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

| Name of person or company | Type of permit | Type of action | Year of action | State |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

6. Please describe if any of the above actions with spouse or an individual with whom you have a personal ownership interest in real property._____

_____

7. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States or of any state or local ordinances? You must include all **misdemeanor and felony convictions**, regardless of the age of the conviction, **including those** which have been set aside and/or dismissed under Penal Code sections 1000 or 1203.4. (Traffic violations of $500 or less need not be reported.)

Yes ☐ No ☐

If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the full penalty received.

8. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks?

Yes ☐ No ☐

If you marked "no" to question 8, please go directly to question 10.

9. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program?

Yes ☐ No ☐

If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

10. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances?

Yes ☐ No ☐

If " yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? Please attach a statement of explanation.

11. Will you work as an employee of this business? Yes ☐ No ☐

If yes, what will your responsibilities and duties be with this business? _____

_____

12. Current and past employment for at least the past five years. (Use additional sheets if necessary.)

| From (month/year) | To (month/year) | Type of work | Firm name and city |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Please read carefully and sign below.

*I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.*

*I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing individual personal affidavit, including all supplementary statements and I personally completed this personal affidavit.*

| Applicant's signature | |
|---|---|
| Title | Date |
| Place | Attest (Notary Public) |

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USCA 405(c)(2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

# INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
**(California Residents)**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

**Take the completed form** to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://caag.state.ca.us/app/contact.pdf or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of $32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

## FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

# REQUEST FOR LIVE SCAN SERVICE

***Applicant Submission***

**ORI:** A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: _____

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916 ) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( N/A )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

# REQUEST FOR LIVE SCAN SERVICE

***Applicant Submission***

**ORI:** A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: _____

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916 ) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( N/A )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

# REQUEST FOR LIVE SCAN SERVICE

***Applicant Submission***

**ORI:** A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: _____

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916 ) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( N/A )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed